11.04: continued

c. The Division will determine the case-mix adjusted capital costs limit (CMCCL) by first sorting acute care Hospital's adjusted costs in ascending order, and then producing a cumulative frequency of discharges. The CMCCL is established at the case-mix adjusted capital cost per discharge corresponding to the median discharge for the FY93 cost to charge calculation, and multiplied by an inflation factor. The year to year inflation factors are: 3.01% for FY94; 2.80% for FY 95; 1.8% for FY96; 1.0% for FY97; no adjustment for FY 98; 0.8% for FY99; no adjustment for FY 00; and 0.9% for FY 01. Sole Community Hospitals, Specialty Hospitals, and Public Service Hospitals will be excluded from this calculation.

d. Each Hospital's case-mix adjusted capital cost per discharge determined in 114.6 CMR 11.04(4)(c)2.b. is then compared to the case-mix adjusted capital costs limit (CMCCL) calculated in 114.6 CMR 11.04(4)(c)2.c..

e. For Hospitals whose own case-mix adjusted capital cost per discharge is less than or equal to the CMCCL, reasonable capital cost per discharge is equal to the Hospital's actual adjusted capital cost per discharge multiplied by the Hospital's case-mix index.

For Hospitals whose own case-mix adjusted capital cost per discharge is greater than the CMCCL, the reasonable capital cost per discharge is equal to the product of a) the CMCCL, and b) the Hospital's case-mix index.

f. The Division will determine reasonable inpatient capital costs by multiplying the reasonable capital cost per discharge calculated in 114.6 CMR 11.04(4)(c)2.e. by total discharges.

For Sole Community Hospitals, Specialty Hospitals, and Public Service Hospitals, reasonable inpatient capital costs equal actual inpatient capital costs.

3. Allowance for Free Care Provided by Physicians. The Division will increase the reasonable costs of qualifying Disproportionate Share Hospitals to include an allowance for Free Care provided by physicians.

a. The Division will allocate $2,500,000 for this allowance.

b. Hospitals will qualify for the allowance for Free Care provided by physicians if they qualify for the High Public Payer Hospital Disproportionate Share Adjustment pursuant to 114.1 CMR 36.07(2).

c. The Division will multiply each qualifying Hospital's allowable Free Care Charges by a Cost to Charge Ratio to determine Allowable Free Care Costs. The Division will use (1) Free Care Charges from the most recent available fiscal year and (2) the Cost to Charge Ratio for the fiscal year closest to the year being processed.

d. The Division will then determine the sum of the amounts determined pursuant to 114.6 CMR 11.04(4)(c)3.e. for all Hospitals that qualify for an allowance for Free Care provided by physicians.

e. Each Hospital's allowance for Free Care provided by physicians is equal to $2,500,000 times the ratio of the Hospital's Allowable Free Care Costs determined in 114.6 CMR 11.04(4)(c)3.c. to the total Allowable Free Care Costs of all qualifying Hospitals determined in 114.6 CMR 11.04(4)(c)3.d..

f. The Division will increase the reasonable costs of eligible Hospitals by 'grossing up" the allowance to the level of total costs. The Division will divide the allowance for each Hospital pursuant to 114.6 CMR 11.04(4)(c)3.e. by the ratio of allowable Free Care Charges to total Charges pursuant to 114.6 CMR 11.04(4)(c)3.c.. The resulting amount will be added to total reasonable costs for the Hospital.

g. The Division will complete this calculation before the beginning of the Fiscal Year.

h. A Hospital which receives an allowance for the cost of Free Care provided by physicians must use the portion of Uncompensated Care Pool payments attributable to such allowance to reimburse such physicians for such Free Care .

4. Allowance for Undocumentable Free Care. The Division will increase the reasonable costs of qualifying Disproportionate Share Hospitals to include an allowance for undocumentable Free Care. This allowance is intended to contribute toward reimbursing Hospitals for Free Care provided to patients who are incapable of providing documentation of Free Care eligibility, but are patients who the Hospital has strong reason to believe would qualify for Free Care.

11.04: continued

a. The Division will allocate $1,000,000 for this allowance.
b. Hospital will qualify for the allowance for Undocumentable Free Care if they qualify for the High Public Payer Hospital Disproportionate Share Adjustment pursuant to 114.1 CMR 36.07(2).
c. The Division will multiply each qualifying Hospital's allowable Free Care Charges by a Cost to Charge Ratio to determine Allowable Free Care Costs. The Division will use (1) Free Care Charges from the most recent available fiscal year; and (2) the Cost to Charge Ratio for the fiscal year closest to the year being processed.
d. The Division will then determine the sum of the amounts determined pursuant to 114.6 CMR 11.04(4)(c)4.c. for all Hospitals that qualify for an allowance for undocumentable Free Care.
e. Each Hospital's allowance for undocumentable Free Care is equal to $1,000,000 times the ratio of the Hospital's Allowable Free Care Costs determined in 114.6 CMR 11.04(4)(c)4.c. to the total Allowable Free Care Costs of all qualifying Hospitals determined in 114.6 CMR 11.04(4)(c)4.d..
f. The Division will increase the reasonable costs of eligible Hospitals by "grossing up" the allowance to the level of total costs. The Division will divide the allowance for each Hospital pursuant to 114.6 CMR 11.04(4)(c)4.e. by the ratio of allowable Free Care Charge to total Charges pursuant to 114.6 CMR 11.04(4)(c)4.d.. This amount will be added to total reasonable costs.
g. The Division will complete this calculation before the beginning of the Fiscal Year.

(5) Estimated Monthly Payments. The Division will calculate each Hospital's payment to and from the Uncompensated Care Pool for a Fiscal Year by estimating its liability to and from the Uncompensated Care Pool and crediting any payments made to and from the Uncompensated Care Pool for each Fiscal Year.

(a) Estimated Hospital Liability to Pool. The Division will calculate and process monthly Hospital payments. The Division will calculate the estimated liability based on data contained in each Hospital's most recently submitted UC Forms for Private Sector Charges, Free Care Charges and Emergency Bad Debt Charges. The Division will estimate the Hospital's annual gross liability to the pool by multiplying its Private Sector Charges times the ratio of total Hospital liability to the pool to total Private Sector Charges for all Hospitals. The Division will notify each Hospital of its calculations of estimated liability.
(b) If a Hospital does not report the data required to calculate the Hospital's payment, the Division may substitute the required data elements with relevant industry averages, prior year reports by the Hospital, or other appropriate data.
(c) The Division may adjust payments to reflect Uncompensated Care Pool expenses for activities authorized in M.G.L. c. 118G and to reflect major changes including, but not limited to, Hospital closures, mergers, and changes in ownership.
(d) The Division may borrow against the penalty, late fee, and interest revenue collected pursuant to 114.6 CMR 11.04(8) to cover unpaid liabilities until such time as these liabilities may be collected.

(6) Final Settlements.

(a) General. There will be a final settlement between the Uncompensated Care Pool and a Hospital for a Fiscal Year. The Final Settlement will be calculated based upon the hospital's gross liability to the Pool as determined pursuant to 114.6 CMR 11.04(2), the Pool's gross liability to the Hospital as determined pursuant to 114.6 CMR 11.04(3), and the payments made to the Hospital during the Fiscal Year. If the difference is positive, the difference is the amount of the hospital's liability to the Pool. If the difference is negative, the difference is the amount of the Pool's liability to the Hospital.
(b) Calculation. The Final Settlement will occur upon completion of the relevant audit and calculations by the Division for that Fiscal Year. Final settlements will be determined using actual Private Sector Charges, final Cost to Charge Ratios and actual Free Care Charges, adjusted for any audit findings; and will include interim payment reconciliations, special payments, and estimated payments to and from the Uncompensated Care Pool.

11.04: continued

(c) The Division may use penalty and interest revenue collected pursuant to 114.6 CMR 11.04(8) to cover:

1. unpaid liabilities from the settlement year that the Division determines to be uncollectible;
2. payments for free care to Community Health Centers; and
3. Shortfall Amounts for any fiscal year.

(7) Administrative Adjustment. A Hospital may request an administrative adjustment if it maintains that the Division's determination of the Hospital's Pool liability for Estimated Monthly Payments or Final Settlement contains a mechanical error. In order to request an adjustment, the Hospital must:

(a) submit a written request which describes the technical errors for which the Hospital seeks correction within 21 days of receiving notice of the Division's determination;

(b) submit documentation supporting the request, including documentation of proposed data changes if the Hospital claims that the calculation used incorrect data;

(c) If the Hospital's request does not contain the required information, the Division will give the Hospital written notice that it must supply the missing information within ten days. If the Hospital fails to comply with this notice, the Division will deny the Hospital's request for administrative review.

(d) After reviewing the documentation, the Division will issue a written decision. The decision will state whether the Division will adjust the Division's determination of net payment to or from the pool and will explain the reasons for this decision.

(8) Penalties.

(a) If a Hospital does not pay its liability amount by the due date, the Division will assess a 1.5% penalty on the outstanding balance. The Division will calculate the penalty from the due date. The Division will assess an additional 1.5% penalty against the outstanding balance and prior penalties for each month that a Hospital remains delinquent. The Division will credit partial payments from delinquent Hospitals to the current outstanding liability. If any amount remains, the Division will then credit it to the penalty amount.

(b) The Division may reduce a Hospital's penalty at the Division's discretion. In determining a waiver or reduction, the Division's consideration will include, but will not be limited to, the Hospital's payment history, financial situation, and relative share of the payments to the Uncompensated Care Pool.

(c) The Division may adjust the cost to charge ratio of any hospital that fails to submit required data, including but not limited to, DHCFP-403 or case mix data. The hospital's allowable free care reimbursement will be reduced by 5% for each month the hospital fails to file the required data. Failure to file the required data for more than two consecutive years may lead to denial of free care reimbursement.

(9) Other Provisions.

(a) The Division may adjust Pool calculations to reflect determinations made under eligibility and compliance audits pursuant to 114.6 CMR 10.00.

(b) Effective FY 1997, the Martha's Vineyard Hospital, Inc. will have no further liability to or from the Uncompensated Care Pool.

(c) For the Commonwealth's FY 1997 and 1998, beginning July 1 1996 and July 1, 1997, respectively, any Specialty Hospital that provides Free Care and whose gross outpatient service revenue equals at least 80% of its total Gross Patient Service Revenue as of January 1, 1996, will be exempt from the provisions of 114.6 CMR 11.04. The Division will determine the amount owed to the pool for these Fiscal Years by the Specialty Hospital. The Division will transfer from Compliance Liability revenues into the Uncompensated Care Pool an amount equal to the amount owed by the Specialty Hospital for state Fiscal Years 1997 and 1998.

11.04: continued

(d) Beginning in FY 1997, the Uncompensated Care Pool will make a one-time payment to Hospitals as early in the Fiscal Year as is administratively feasible. The total amount of this payment to all hospitals will equal the amount of supplemental funding available, less any amount transferred pursuant to 114.6 CMR 11.04(9)(c). This payment will be allocated to individual Hospitals in accordance with 114.6 CMR 11.04(4), using the preliminary Cost to Charge Ratio. The Division may offset any funds distributed under 11.04(9)(d) by any amounts owed by Hospitals for current or prior years' unpaid liabilities. These payments will be included in final settlements calculated pursuant to 114.6 CMR 11.04(6).

11.05: Surcharge on Hospital Payments

(1) General. There is a surcharge on certain payments to Hospitals and Ambulatory Surgical Centers. The surcharge amount equals the product of (a) payments subject to surcharge as defined in 114.6 CMR 11.05(1)(b) and (b) the Surcharge Percentage as defined in 114.6 CMR 11.05(2).

(a) Surcharge Payer.

1. A Surcharge Payer is an individual or entity that makes payments for the purchase of health care Hospital Services and Ambulatory Surgical Center Services; provided, however, that the term "surcharge payer" shall not include (1) Title XVIII and Title XIX programs and their beneficiaries or recipients; (2) other governmental programs of public assistance and their beneficiaries or recipients; and (3) the workers compensation program established pursuant to M.G.L. c.152.

2. The same entity that pays that Hospital or ambulatory surgical center for services must pay the surcharge. If an entity such as a Third Party Administrator acts on behalf of a client plan and uses the client plan's funds to pay for the services, or advances funds to pay for the services for which it is reimbursed by the client plan, it must also act on behalf of the client plan and use the client plan's funds to pay the surcharge or advance funds to pay the surcharge for which it will be reimbursed by the client plan.

(b) Payments Subject to Surcharge. Payments subject to surcharge include:

1. direct and Indirect Payments made by Surcharge Payers on or after January 1, 1998, regardless of the date services were provided, to:(1) Massachusetts acute hospitals for the purchase of acute Hospital Services; and (2) Massachusetts Ambulatory Surgical Centers for the purchase of Ambulatory Surgical Center Services.

2. payments made by national health insurance plans operated by foreign governments; and payments made by an embassy on behalf of a foreign national not employed by the embassy.

(c) Payments not Subject to Surcharge. Payments not subject to surcharge include:

1. payments, settlements and judgments arising out of third party liability claims for bodily injury which are paid under the terms of property or casualty insurance policies;

2. payments made on behalf of Medicaid recipients, Medicare beneficiaries, or persons enrolled in policies issued pursuant to M.G.L. c. 176K or similar policies issued on a group basis;

3. payments made by a Hospital to a second Hospital for services which the first Hospital billed to a Surcharge Payer;

4. payments made by a group of providers, including one or more Massachusetts acute care Hospitals or Ambulatory Surgical Centers, to member Hospitals or Ambulatory Surgical Centers for services which the group billed to an entity licensed or approved under M.G.L. c.175, c.176A, c.176B, c.176G, or c.176I;

5. payments made on behalf of an individual covered under the Federal Employees Health Benefits Act at 5 U.S.C. 8901 *et seq.*;

6. payments made on behalf of an individual covered under the workers compensation program under M.G.L. c. 152; and

7. payments made on behalf of foreign embassy personnel who hold a Tax Exemption Card issued by the United States Department of State.

(d) The surcharge shall be distinct from any other amount paid by a Surcharge Payer for the services provided by a Hospital or Ambulatory Surgical Center. Surcharge amounts paid shall be deposited in the Uncompensated Care Pool.

11.05: continued

(2) Calculation of the Surcharge Percentage. The Division will use the following methodology to calculate the percentage of the surcharge to be assessed on certain payments to Hospitals and Ambulatory Surgical Centers, established in M.G.L. c.118G, §18A, as added by St. 1997, c. 47.

(a) The Division will project FY 1998 annual aggregate payments subject to the surcharge as follows. The following data will be obtained for Pool FY 1996, or adjusted for inflation to Pool FY 1996.

1. The Division will determine total payments received by Massachusetts acute care Hospitals from private managed care, non-managed care, and self-pay payers by subtracting bad debt written off and gross payments from the Pool allocated to those payers from net patient service revenue allocated to those payers, as reported on the DHCFP-403 cost report.
2. The Division will determine total payments received by Massachusetts Ambulatory Surgical Centers for Ambulatory Surgical Center Services from private managed care, non-managed care, and self-pay payers from data reported by these centers to the Division.
3. The Division will determine payments from HMOs licensed in Massachusetts to Massachusetts acute care Hospitals and Ambulatory Surgical Centers that are exempt from the surcharge from data provided by these HMOs to the Division.
4. The Division will estimate the amount of payments, settlements and judgments arising out of third party liability claims for bodily injury which are paid under the terms of property or casualty insurance policies based on data provided by the Auto Insurers Bureau.
5. The Division will estimate the amount of surcharge payments that will be below the threshold for collection based on sample data provided by Hospitals.
6. The Division will make an allowance for uncollectible amounts.
7. The Division will add the amounts determined in 114.6CMR11.05(2)(a)1. and 2. and subtract the amounts determined in 114.6 CMR 11.05(2)(a)3., 4., 5. and 6.. The Division will then adjust this total amount of FY 1996 payments subject to the surcharge to reflect price changes between FY 1996 and FY 1998. The Division will use a blend of the HCFA market basket and the Massachusetts Consumer Price Index (CPI) to reflect conditions in the Massachusetts economy. Specifically, the labor-related component of the HCFA market basket will be replaced by the CPI. This adjusted amount will be the Division's projected FY 1998 annual aggregate payments subject to the surcharge.

(b) The Division will calculate the Surcharge Percentage effective January 1, 1998 as follows, in order to ensure that the amount loaned to the Pool will be fully repaid to the General Fund by June 30, 1998.

1. The Division will multiply $100,000,000 by 2/12 and add this product to $100,000,000, in order to account for the two month delay in payment of the surcharge.
2. The Division will multiply the projected FY 98 annual aggregate payments subject to the surcharge, determined pursuant to 114.6 CMR 11.05(2)(a), by 9/12, in order to collect the full amount of the surcharge in nine months.
3. The Division will divide the amount determined in 114.6 CMR 11.05(2)(b)1. by the amount determined in 114.6 CMR 11.05(2)(b)2.

This calculation can be expressed as the following formula.

PAAPSS = projected annual aggregate payments subject to the surcharge

Surcharge Percentage effective January 1, 1998 =

[100,000,000 + ((2/12)*100,000,000)] / [(9/12) * FY 98 PAAPSS]

(c) If the Division projects that the Surcharge Percentage established in 114.6 CMR 11.05(2)(b) will produce less than $90,000,000 or more than $100,000,000 by September 30, 1998, or that an adjustment is necessary in order to fully repay the General Fund by June 30, 1998 then the Division may redetermine the Surcharge Percentage as of May 1, 1998 and as of July 1, 1998 pursuant to the following methodology.

11.05: continued

1. The Division will project FY 98 annual aggregate payments subject to the surcharge based on historical data, with any adjustments the Divisions deems necessary.
2. The Division will multiply $100,000,000 by two twelfths (2/12) and add this product to $100,000,000, in order to account for the two month delay in payment of the surcharge.
3. The Division will multiply the projected FY 98 annual aggregate payments subject to the surcharge, determined pursuant to 114.6 CMR 11.05(3)(c)1., by nine twelfths (9/12), in order to collect the full amount of the surcharge in nine months.
4. The Division will divide the amount determined in 114.6 CMR 11.05(3)(c)2. by the amount determined in 114.6 CMR 11.05(2)(c)3.

This calculation can be expressed as the following formula.

PAAPSS = projected annual aggregate payments subject to the surcharge

Surcharge Percentage effective May 1, 1998 or July 1, 1998 =

[100,000,000 + ((2/12)*100,000,000)] / [(9/12) * FY 98 PAAPSS]

(d) The Division will establish the Surcharge Percentage effective October 1 of 1998 and each successive year before September 1 of each year, using the following methodology.

1. The Division will determine the total amount to be collected by adjusting $100,000,000 for any over or under collections from Institutional Payers and individuals in previous years, including audit adjustments, as well as any over or under collections projected for October or November of the coming year.
2. The Division will project annual aggregate payments subject to the surcharge based on historical data, with any adjustments the Division deems necessary.
3. The Division will divide the amount determined in 114.6 CMR 11.05(2)(d)1. by the amount determined in 114.6 CMR 11.05(2)(d)2.

(3) Payer Registration.

(a) Except for non-United States national insurers which have made less than ten payments per year in the prior three years to Massachusetts Hospitals and/or Ambulatory Surgical Centers, all Institutional Payers must register with the Division by completing and submitting the Uncompensated Care Pool Surcharge Payer Registration form. Institutional Payers must register only once. These payers shall submit the Registration form to the Division before December 10, 1997 for Pool Fiscal Year 1998; or within 30 days after making a payment to any Massachusetts Hospital or Ambulatory Surgical Center.

(b) Registered Payer List. The Division will compile lists of registered Institutional Payers, and will update the lists quarterly. The Division will distribute these lists to Hospitals and Ambulatory Surgical Centers.

(c) Institutional Payers must register only once. A Registered Payer is automatically registered for the next Fiscal Year.

(4) Billing Process for Institutional Payers.

(a) Each Hospital and Ambulatory Surgical Center shall send a bill for the Uncompensated Care Pool surcharge to Surcharge Payers, as required by M.G.L. c.118G, § 18A(b). Hospitals and Ambulatory Surgical Centers shall send this bill to Surcharge Payers from whom they have received payment for services in the most recent four quarters for which data is available. The bill will state the Surcharge Percentage. Hospitals and Ambulatory Surgical Centers shall send this bill to payers before September 1 of each Fiscal Year and before the effective date of any Surcharge Percentage.

11.05: continued

(b) Each Hospital and Ambulatory Surgical Center shall also send a bill for the surcharge at the same time as the bill for services provided to Institutional Payers who have not registered with the Division pursuant to 114.6 CMR 11.05(3)(a) and from whom they have received payment. The bill must be sent within 30 days of receiving the payment from the unregistered payer. The bill shall state the Surcharge Percentage, but not the dollar amount owed, and shall include notification of the surcharge payment process set forth below, as well as a registration form specified by the Division. Until the Hospital or Ambulatory Surgical Center receives the Registered Payer List, it shall send a bill for the surcharge at the same time as the bill for services provided to Institutional Payers which it did not already bill pursuant to 114.6 CMR 11.05(4)(a).

(5) Payment Process for Institutional Payers.

(a) Monthly Surcharge Liability. After the end of each calendar month, each Institutional Payer shall determine the surcharge amount it owes to the Pool for that month. The amount owed is the product of the amount of payments subject to surcharge, as defined in 114.6 CMR 11.02, by the Surcharge Percentage in effect during that month. The Institutional Payer may adjust the surcharge amount owed for any surcharge over- or under-payments in a previous period.

1. Institutional Payers that pay a global fee or capitation for services that include Hospital or ambulatory surgical services, as well as other services not subject to the surcharge, must develop a reasonable method for allocating the portion of the payment intended to be used for services provided by Hospitals or Ambulatory Surgical Centers. Such Institutional Payers must file this allocation method with the Division before January 1, 1998 for Pool Fiscal Year 1998; before October 1, 1998 for Pool Fiscal Year 1999; and before each successive October 1 for future Pool years. If there is a significant change in the global fee or capitation payment arrangement that necessitates a change in the allocation method, the Institutional Payer must file the new method with the Division before the new payment arrangement takes effect. Institutional Payers may not change the allocation method later in the year unless there is a significant change in the payment arrangement.

a. The Division will review allocation plans within 90 days of receipt. During this review period the Division may require an Institutional Payer to submit supporting documentation or to make changes in this allocation method if it finds that the method does not reasonably allocate the portion of the global payment or capitation intended to be used for services provided by Hospitals or Ambulatory Surgical Centers.

b. An Institutional Payer must include the portion of the global payment or capitation intended to be used for services provided by Hospitals or Ambulatory Surgical Centers, as determined by this allocation method, in its determination of payments subject to surcharge.

2. An Institutional Payer must include all payments made as a result of settlements, judgments or audits in its determination of payments subject to surcharge. An Institutional Payer may include payments made by Massachusetts Hospitals or Ambulatory Surgical Centers to the Institutional Payer as a result of settlements, judgments or audits as a credit in its determination of payments subject to surcharge.

(b) Monthly Payments. Institutional Payers shall make payments to the Pool monthly. Each Institutional Payer shall remit the surcharge amount it owes to the Pool, determined pursuant to 114.6 CMR 11.05(5)(b), to the Division for deposit in the Pool. Institutional Payers shall remit the surcharge payment by the first business day of the second month following the month for which the surcharge amount was determined. For example, surcharge payments based on payments made to Hospitals and Ambulatory Surgical Centers in January are due to the Pool on March 1.

(c) Biannual Surcharge Payment Option.

1. Eligible Surcharge Payers. The Division will review each registered Surcharge Payer's payment history to determine if it is eligible for this option. In order to qualify, the Surcharge Payer must:

a. have remitted required surcharge payments and submitted all monthly coupons and the Surcharge Verification Form for the period January, 1998 through June, 1999; and

11.05: continued

b. have reported payments less than $10,000 in the Surcharge Verification Form.

2. Ambulatory Surgical Centers, which are required to remit monthly surcharge payments due from self payers, may be eligible if they meet the criteria listed above. Hospitals must continue to file monthly notices.

3. The Division will notify payers eligible for the biannual option. The Payer may elect to receive biannual surcharge notices or to continue to receive monthly notices. Each biannual surcharge payments will equal (1) the appropriate surcharge percentage times (2) payments made to Massachusetts hospitals and ambulatory surgical centers for the prior six months.

(d) All surcharge payments must be payable in United States dollars and drawn on a United States bank. The Division will assess a $30 penalty on any Surcharge Payer whose check is returned for insufficient funds.

(e) Any Institutional Payer, except Third Party Administrators, which has a surcharge liability of less than five dollars in any month or biannual payment period may delay payment until its surcharge liability is at least five dollars. For example, XYZ Company's surcharge liability for July is $3.50 and its liability for August is $2.00. XYZ Company may delay payment in July but must remit a check for $5.50 in August.

(6) Payment Process for Individual Payers (Self-pay). There is a surcharge on certain payments made by Individual Payers to Hospitals and Ambulatory Surgical Centers.

(a) Billing.

1. Hospitals and Ambulatory Surgical Centers shall include the surcharge amount on all bills to Individual Payers unless:

a. the patient's liability is less than the individual payment threshold determined by the Division. The individual payment threshold is a payment of $10,000 or more.

b. the patient is a non-Massachusetts resident for which the Hospital or Ambulatory Surgical Center can verify that the patient's family income would otherwise qualify the patient for Free Care according to the requirements of 114.6 CMR 10.03

c. the patient is approved for Medical Hardship in accordance with the requirements of 114.6 CMR 10.03(3). The bill shall direct Individual Payers to pay the surcharge to the Hospital or Ambulatory Surgical Center when making payment for services.

2. The amount of the surcharge billed is the product of:

a. the patient's liability to the Hospital or Ambulatory Surgical Center; and

b. the Surcharge Percentage in effect on the billing date.

3. The amount of the surcharge owed by an Individual Payer is the product of:

a. the total amount paid by the individual to a Hospital or Ambulatory Surgical Center; and

b. the Surcharge Percentage in effect on the payment date. Payments greater than or equal to the threshold received by Hospitals and Ambulatory Surgical Centers from Individual Surcharge Payers are subject to the surcharge.

(b) Hospitals and Ambulatory Surgical Centers must remit to the Division the surcharge amount owed by Individual Payers for every payment greater than or equal to the threshold made by Individual Payers. If an Individual Payer makes separate payments over a twelve month period which are equal to or greater than the threshold and relate to an outpatient visit or inpatient stay, the surcharge amount due applies to the aggregate amount paid for the outpatient visit or inpatient stay. The first surcharge payment is due to the Division when the total Individual Payer payment amount reaches the threshold.

(c) Hospitals and Ambulatory Surgical Centers shall remit such surcharge payments by the first business day of the second month following the month during which the surcharge was received. For example, surcharge payments received by Hospitals and Ambulatory Surgical Centers in January are due to the Pool on March 1. Hospitals and Ambulatory Surgical Centers may deduct collection agency fees for the collection of surcharge payments from Individual Payers from the total amount of surcharge payments forwarded to the Pool.

(d) All payments must be payable in United States dollars and drawn on a United States bank. The Division will assess a $30 penalty on any Surcharge Payer whose check is returned for insufficient funds.

11.05: continued

(e) If an embassy of a foreign government pays a hospital or ambulatory surgical center bill on behalf of an individual, the provider may either:

1. bill the embassy for the individual's surcharge according to the billing and payment process for individual payers set forth in 114.6 CMR 11.05(6); or
2. bill the embassy according to the billing process for Institutional Payers as set forth in 114.6 CMR 11.05(4). If the provider chooses to bill the embassy as an Institutional Payer and the embassy is not listed on the Registered Payer List, the provider shall include the embassy on the Unmatched Payer Report and send surcharge payer registration information to the embassy.

(7) Penalties.

(a) If a Hospital, Ambulatory Surgical Center, or Surcharge Payer fails to forward surcharge payments pursuant to 114.1 CMR 11.05, the Division shall impose an additional 1.5% interest penalty on the outstanding balance. The interest shall be calculated from the due date. For each month a payment remains delinquent, an additional 1.5% penalty shall accrue against the outstanding balance, including prior penalties.

1. The Division will credit partial payments first to the current outstanding liability, and second to the amount of the penalties.
2. The Division may reduce the penalty at the Division's discretion. In determining a waiver or reduction, the Division's consideration will include, but will not be limited to, the entity's payment history, financial situation, and relative share of the payments to the Uncompensated Care Pool.

(b) The Division may deny reimbursement for Free Care to any Hospital which fails to remit surcharge payments as required by 114.6 CMR 11.05(4)(b) until such Hospital remits the required amounts. The Division will notify such Hospital of its intention to withhold reimbursement.

(8) Administrative Review. The Division may conduct an administrative review of surcharge payments at any time.

(a) The Division will review data submitted by Hospitals, Ambulatory Surgical Centers, and Institutional Payers pursuant to 114. CMR 11.03, the Uncompensated Care Pool Surcharge Payer Registration forms submitted by Institutional Payers pursuant to 114.6 CMR 11.05(3)(a), and any other pertinent data. All information provided by, or required from, any Surcharge Payer, pursuant to 114.6 CMR 11.00 shall be subject to audit by the Division.

For surcharge payments based upon a global fee or capitation allocated according to an allocation method accepted by the Division pursuant to 11.05(5)(a)1., the Division's review will be limited to determining whether this method was followed accurately and whether the amounts reported were accurate.

(b) The Division may require the Surcharge Payer to submit additional documentation reconciling the data it submitted with data received from Hospitals.

(c) If the Division determines through its review that a Surcharge Payer's payment to the Pool was materially incorrect, the Division may require a payment adjustment. Payment adjustments shall be subject to interest penalties and late fee, pursuant to 114.6 CMR 11.05(7), from the date the original payment was owed to the Pool. Payment adjustments may also be offset from Division of Medical Assistance payments, pursuant to 114.6 CMR 11.07(1).

(d) Processing of Payment Adjustments.

1. Notification. The Division shall notify a Surcharge Payer of its proposed adjustments. The notification shall be in writing and shall contain a complete listing of all proposed adjustments, as well as the Division's explanation for each adjustment.
2. Objection Process. If a Surcharge Payer wishes to object to a Division proposed adjustment contained in the notification letter, it must do so in writing, within 15 business days of the mailing of the notification letter. The Surcharge Payer may request an extension of this period for cause. The written objection must, at a minimum, contain:
   a. each adjustment to which the Surcharge Payer is objecting,
   b. the Fiscal Year for each disputed adjustment,
   c. the specific reason for each objection, and
   d. all documentation which supports the Surcharge Payer's position.

11.05: continued

3. Upon review of the Surcharge Payer's objections, the Division shall notify the Surcharge Payer of its determination in writing. If the Division disagrees with the Surcharge Payer's objections, in whole or in part, the Division shall provide the Surcharge Payer with an explanation of its reasoning.

4. The Surcharge Payer may request a conference on objections after receiving the Division's explanation of reasons. The Division will schedule such conference on objections only when it believes that further articulation of the Surcharge Payer's position is beneficial to the resolution of the disputed adjustments.

(e) Payment of Adjustment Amounts. Adjustment amounts and any interest penalty and late fee amounts shall be due to the Pool 30 calendar days following the mailing of the Notification letter issued pursuant to 114.6 CMR 11.05(8)(d)1. If the Surcharge Payer submitted a written objection, then adjustment amounts and any interest penalty and late fee amounts shall be due to the Pool 30 calendar days following the mailing of the Division's determination issued pursuant to 114.6 CMR 11.05(8)(d)3. The Division may establish a payment schedule for adjustment amounts, pursuant to 114.6 CMR 11.03(5)(d).

11.06: Payments to Community Health Centers

(1) The Division will establish a rate for an Individual Medical Visit with a physician for each Community Health Center equal to the Community Health Center's approved 1995 Federally Qualified Health Center (FQHC) annual rate, or in the circumstances of a non-FQHC approved Community Health Center, a rate based upon a substitute annual cost report in the same format.

(2) Full Free Care.

(a) The Division will pay for an Individual Medical Visit at a percentage of the 1995 FQHC rate based on the following table:

Physician	100%
Nurse Practitioner, Nurse Midwives or Physician Assistant	100%
Dentist	75%
Clinical Psychologist	50%
Licensed Social Worker	50%

(b) The Division will pay the following amounts for services provided on-site at the Community Health Center:

Ancillary Laboratory	25% of Charges
Ancillary Radiology	25% of Charges
Ancillary Miscellaneous	25% of Charges

(3) Partial Free Care and Medical Hardship. The Division will pay for services provided to patients who meet the criteria set forth in 114.6 CMR 10.03(2) for Partial Free Care or 114.6 CMR 10.03(3) for Medical Hardship.

11.07: Special Provisions

(1) Division of Medical Assistance (DMA) Payment Offset for Hospitals and Surcharge Payers. If a Hospital or Surcharge Payer fails to make scheduled payments and maintains an outstanding obligation to the Pool for more than 45 days, the Division may notify DMA to offset payments on the claims of the Hospital or Surcharge Payer, or any entity under common ownership, as defined in 130 CMR 450.101, or any successor in interest to the Hospital or Surcharge Payer, in the amount of payment owed to the Uncompensated Care Pool, including accrued interest, penalties and late fee. Payments offset in accordance with this provision shall be credited to the Hospital's or Surcharge Payer's outstanding liability to the Pool.

(a) The Division shall notify the Hospital or Surcharge Payer in writing of the dollar amount to be offset from the Surcharge Payer's DMA claims. Such notification shall be sent to the Hospital or Surcharge Payer via certified mail at least ten days prior to notifying DMA.

11.07: continued

(b) If a Hospital or Surcharge Payer believes the amount to be offset is incorrect because of an arithmetic, mechanical or clerical error, it may object in writing during this ten day period to the Division of Health Care Finance and Policy. The written objection must contain an explanation of the perceived error as well as documentation to support the Hospital's or Surcharge Payer's objection. No objection by the Hospital or Surcharge Payer regarding the payment offset is appealable to DMA.

(c) Upon review of the Hospital's or Surcharge Payer's objections, the Division shall notify the Hospital or Surcharge Payer of its determination in writing. If the Division disagrees with the Hospital's or Surcharge Payer's objections, in whole or in part, the Division shall provide the Surcharge Payer with an explanation of its reasoning.

(d) The Division shall notify DMA in writing of the dollar amount to be offset from the Hospital's or Surcharge Payer's DMA claims.

(e) Hospitals and Surcharge Payers to which payment is offset must serve all Title XIX recipients in accordance with the contract then in effect with the Division of Medical Assistance, or, in the case of a non-contracting Hospital or Disproportionate Share Hospital, in accordance with its obligation for providing services to Title XIX recipients pursuant to M.G.L. c. 118G.

(2) Financial Hardship. A Hospital or Surcharge Payer may request a deferment or partial payment schedule due to financial hardship.

(a) In order to qualify for such relief, the Hospital or Surcharge Payer must demonstrate that its ability to continue as a financially viable going concern will be seriously impaired if payments pursuant to 114.6 CMR 11.04 or 114.6 CMR 11.05 were made.

(b) If the Division finds that payments would be a financial hardship, the Division may, at its discretion, establish the terms of any deferment or partial payment plan deferment. The deferment or payment schedule may include an interest charge.

1. The interest rate used for the payment schedule shall not exceed the prime rate plus 2%. The prime rate used shall be the rate reported in the *Wall Street Journal* dated the last business day of the month preceding the establishment of the payment schedule.
2. A Surcharge Payer may make a full or partial payment of its outstanding liability at any time without penalty.
3. If a Surcharge Payer fails to meet the obligations of the payment schedule, the Division may assess penalties pursuant to 114.6 CMR 11.05.

(3) Severability. The provisions of 114.6 CMR 11.00 are severable. If any provision or the application of any provision to any Hospital, Community Health Center, surcharge payer or Ambulatory Surgical Center or circumstances is held to be invalid or unconstitutional, and such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.60 CMR 11.00 or the application of such provisions to Hospitals, Community Health Centers or circumstances other than those held invalid.

(4) Administrative Information Bulletins. The Division may issue administrative information bulletins to clarify policies and understanding of substantive provisions of 114.6 CMR 11.00 and specify information and documentation necessary to implement 114.6 CMR 11.00.

REGULATORY AUTHORITY

114.6 CMR 11.00: M.G.L. c. 118G.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

Exhibit 7

105 CMR 160.000
114.3 CMR 46.00

105 CMR 160.000: ACUTE CARE INPATIENT SUBSTANCE ABUSE DETOXIFICATION TREATMENT SERVICES

Section

Section: continued

160.001: Purpose

105 CMR 160.000 sets forth standards for the maintenance and operation of acute care inpatient substance abuse detoxification treatment services.

160.002: Authority

105 CMR 160.000 is adopted under the authority of M.G.L. c. 111B, § 6 and c. 111E, § 7.